No. 98-1949

IN THE

Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION and HEALTH ALLIANCE MEDICAL PLANS, INC.,

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR RESPONDENT

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QUESTION PRESENTED

Whether a non-sponsor fiduciary may design and administer an ERISA benefit plan so as to increase its profits to the detriment of the plan participants.

PARTIES TO THE PROCEEDING

Carle Clinic Association, P.C. is an Illinois professional corporation comprised of licensed physicians, dentists and podiatrists. Health Alliance Medical Plans, Inc. is a for-profit Illinois domestic stock insurance company and is a wholly-owned subsidiary of Carle Clinic Association, P.C. (Resp. app. 42a). Carle Health Insurance Management Company is a for-profit Illinois corporation and is a wholly-owned subsidiary of Carle Clinic Association, P.C. (Resp. app. 42a).

These three entities file a consolidated income tax return. (Resp. app. 44a). Pursuant to Article III, Section 2 of Health Alliance's corporate by-laws, an appointment to the Board of Governors of Carle Clinic Association, P.C. results in an automatic appointment to the Board of Directors of Health Alliance. (Resp. app. 45a).

Neither Dr. Pegram, nor any other individual physician, is a party defendant in Amended Count III. (Pet. app. 83a).

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STATEMENT OF THE CASE

In March of 1991, respondent's husband was employed by State Farm Mutual Automobile Insurance Company (hereinafter "State Farm"). (Pet. app. 84a). Through State Farm, Health Alliance Medical Plans, Inc. (hereinafter "HAMP") sold respondent a subscription in CarleCare HMO, a pre-paid health insurance plan. (hereinafter "the Plan") (Pet. app. 84a). The Joint Appendix includes the State Farm "Summary Plan Description" (hereinafter "SPD") for health benefits. State Farm provides its employees with two health insurance options: traditional group medical (section II of SPD) (Jt. app. 51) and an HMO (section III of the SPD). (Jt. app. 101).

State Farm designed and administers the group medical insurance program. (Pet. app. 85a). The SPD description of State Farm's group medical plan is both lengthy and detailed, running from page 51 of the Joint Appendix to page 101. The HMO benefits, on the other hand, are not designed and administered by State Farm. (Pet. app. 85a). Section III (Health Maintenance Organization) of the SPD is very abbreviated, only running from page 101 of the SPD to page 104. Concerning the HMO option, the State Farm SPD states:

> Upon request, information will be provided to any employee interested in the HMOs listed. Information in the form of written materials concerning (a) the nature of services provided to members; (b) conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participating in the HMO) and circumstances under which services may be denied; (c) the procedures to be followed in obtaining such services; and (d) the procedures available for the

review of claims for services which are denied in whole or in part.

Requests for any of the information listed in the above paragraph may be directed to the Plan Administrator and the Plan Administrator will forward all requests to the appropriate HMO carrier. A brief summary of each HMO's benefits, grievance procedures and procedures for submitting eligible expenses appears in the appendix.

Although State Farm Mutual Automobile Insurance Company is the Plan Administrator and Plan Sponsor for the Group Medical Plan (including HMO alternatives), any and all benefit determinations will be made by each individual HMO according to its operating procedures. (Jt. app. 101, 102)

* * *

HEALTH MAINTENANCE ORGANIZATION APPENDIX

THIS APPENDIX TO THE HMO SECTION IS **NOT** MEANT TO BE ALL INCLUSIVE OF "BENEFITS AND RESTRICTIONS PROVIDED BY THE HMO." FOR A SCHEDULE OF **ALL** BENEFITS AND RESTRICTIONS, PLEASE CONTACT THE PLAN ADMINISTRATOR AND REQUEST ADDITIONAL INFOR-MATION. THE HMO WILL BE ASKED TO SEND MORE DETAILED INFORMATION TO YOU.

> On the following pages we have tried to describe the benefits available under the various HMO options. This information has been obtained directly from the HMO's contract or HMO's Representative. If the following information contains any statements that disagree with the HMO contract, then the HMO contract shall govern. (emphasis in original) (Jt. app. 103, 104).

The Plan[1] sets forth a service schedule in section 6 (Pet. app. 102a) which specifies the services which respondent is entitled to receive as a participant. Section 7 of the Plan (Pet. app. 111a) discloses the Plan limitations including the fact that "[d]iagnostic and treatment services by non-CarleCare Physicians are provided only when referred by the Primary Care Physician." (Pet. app. 111a). The Plan also states that participants are limited to care that is medically necessary.

The determination of what is or is not medically necessary is left to the judgment of the Carle physicians. Section 8.3 excludes "services or supplies which are not, in the judgment of CarleCare Physicians, Medically Necessary for the medical treatment or for the maintenance or improvement of the health of the Members." (Pet. app. 118a). Neither the State Farm SPD nor the Carle Subscription Certificate contain any disclosures

1. In her *amicus* brief, the Secretary of Labor (hereinafter "Secretary") argues that the State Farm SPD is "the Plan." This is a distinction without a difference. As stated above, the State Farm SPD defers to the HMO group subscription certificate. The definition of an ERISA "welfare plan" (29 U.S.C. § 1002(1)) includes " 'any plan, fund, or program' maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries 'through the purchase of insurance or otherwise.' " Indeed this court refers to the health certificate itself as "the Plan." *See FMC Corporation v. Holiday*, 498 U.S. 52 (1990).

that Carle physicians have a financial incentive not to treat plan members. Respondent was not advised that, in addition to the specified Plan limitations to which respondent agreed, respondent's treating physicians received bonuses or "supplemental" income derived from the minimization of diagnostic testing, minimization of referrals to specialists, and minimization of use of non-network facilities.

In March of 1991, respondent's primary care physician discovered a 6 x 8 centimeter "mass" (later determined to be her appendix) in respondent's abdomen. 154 F.3d 362, 374. Although the mass was inflamed on March 7, the primary care physician delayed instituting immediate treatment of respondent, and forced her to wait more than one week (eight days) to obtain the accepted diagnostic procedure (ultrasound) used to determine the nature, size and exact location of the mass. Ideally, respondent should have had the ultrasound administered with all speed after the inflamed mass was discovered in her abdomen in order that her condition could be diagnosed and treated before deteriorating as it did, but Carle' policy requires plan participants to receive medical care from Carle-staff facilities. *Id.* Respondent was forced to wait the eight days before undergoing the ultrasound at a Carle facility in Urbana, Illinois. During this unnecessary waiting period, respondent's health problems were exacerbated and her appendix ruptured, resulting in the onset of peritonitis. In an effort to defray the increased costs associated with the surgery required to drain and cleanse respondent's ruptured appendix, Carle insisted that she have the procedure performed at its own Urbana facility, necessitating that respondent travel more than fifty miles from her neighborhood hospital in Bloomington, Illinois. *Id.*

Respondent filed a two-count complaint in state court on October 21, 1992. (Pet app. 3a). Count I alleged medical

negligence against the primary care physician for failing to adequately examine, treat, and follow-up on respondent's complaint of right, lower quadrant pain. Respondent claimed that the primary care physician's failure to employ the skill and care ordinarily used by a reasonably well-qualified physician resulted in a ruptured appendix, which caused peritonitis. Count II sought to hold Carle Clinic Association liable under the theory of respondeat superior. Pegram and Carle Clinic filed an Answer to the state court complaint on December 8, 1992. (Resp. app. 6a).

Because it appeared that all the decisions as to respondent's treatment could be explained on the basis on a profit motive, respondent filed an addendum to her state court complaint in February 1994, adding Counts III and IV. Count III alleged that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plan in violation of the Illinois Consumer Fraud Act, 815 ILCS 505/1 *et seq*. Count IV charged Health Alliance breached its duty of good faith and fair dealing. (Resp. app. 6a).

The petitioners filed a Notice of Removal on March 14, 1994, asserting that Counts III and IV were preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1101, and that the pendant state claims set forth in Counts I and II were removable pursuant to 28 U.S.C. § 1367. Respondent filed a Motion to Remand on April 8, 1994. (Resp. app. 6a).

In opposition to the Motion to Remand, petitioners argued that Counts III and IV related to the administration of a plan and were thus preempted under ERISA. Specifically, petitioners set forth a Synopsis of Relevant Facts which stated that respondent was a participant and beneficiary in an employee

benefit plan ("the Plan") provided to her through her husband's employer, State Farm Insurance Companies. Petitioner's factual synopsis also asserted that Health Alliance was the administrator and fiduciary of the Plan. In their memorandum in opposition to respondent's motion to remand, petitioners stated:

> The plaintiff, respondent, was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her by her husband's employer, State Farm Insurance Companies. ***Defendant, Health Alliance Medical Plans, Inc. ("Health Alliance") was the administrator and fiduciary of the Plan within the meaning of ERISA (29 U.S.C. Section 1001 et seq.)*** (Resp. app. 24a) (emphasis added)
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> * * *
>
> In the case now before this Court, it is clear that the plaintiff's claims relate to the Plan administered by Health Alliance. The relationship between the plaintiff and Health Alliance arose solely from the Plan. ***But for the existence of the Plan, Cynthia Herdrich's participation in that Plan and Health Alliance's serving as administrator/fiduciary of that Plan, there would be no relationship whatsoever between Cynthia Herdrich and Health Alliance and thus no lawsuit***. (Resp. app. 36a) (emphasis added)

Petitioners filed a motion for summary judgment as to counts III and IV only. 154 F.3d 362, 366. The trial court granted summary judgment against respondent on count IV "to the extent (she) relies on § 502(a)(3)(b) (of ERISA) as a basis for monetary relief as opposed to equitable relief" and found that

that provision does not provide for extra-contractual damages. *Id.* While the trial judge denied the petitioner's summary judgment motion as to count III, he did conclude ERISA pre-empted that count, and granted respondent "leave to submit and amended count III which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision." *Id.* On September 1, 1995, respondent filed her amended count III in accordance with the court's instructions. Thereafter, petitioners moved, pursuant to Rule 12(b) of the Federal Rules of Civil Procedure, to dismiss respondent's amended count III for failure to state a claim upon which relief could be granted. 154 F.3d 362, 367.

In dismissing respondent's amended count III, the trial court relied on petitioner's representations that they were ERISA fiduciaries, as reflected in the following findings of the trial court:

> In opposition to the Motion to Remand, Defendants argued that Counts III and IV related to the administration of a plan and were thus preempted under ERISA. Specifically, Defendants set forth a Synopsis of Relevant Facts which stated that Herdrich was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her through her husband's employer, State Farm Insurance Companies. The factual synopsis also asserted that Defendant Health Alliance was the administrator and fiduciary of the Plan. Finally, Defendant contended that as part of the Plan, Health Alliance contracted with Carle Clinic to provide medical care to Plan participants in accordance with an agreed upon fee schedule. (Pet. app. 67a).

* * *

Defendants state, without reference to supporting material, that Carle HMO acts as the fiduciary of the Plan. However, the Defendants also frame the issues contained in the Motion for Summary Judgment as "whether an ERISA plan participant/ beneficiary may sue an ERISA plan fiduciary under Illinois common law and under the Illinois Consumer Fraud Act, 815 ILCS 505/1, *et seq.*, to recover extra-contractual damages," indicating that Carle Clinic and Health Alliance function as fiduciaries. This statement, taken in conjunction with the prior representations made by Defendants, indicates that there are three fiduciaries of the Plan: Carle Clinic, Health Alliance, and Carle HMO. (Pet. app. 69a).

Respondent's malpractice counts went to trial in early December, 1996, and the jury returned a verdict in respondent's favor, awarding her $35,000 in compensatory damages. Because respondent's ERISA count had been dismissed, the jury heard no evidence concerning the fact that respondent's physicians had a financial incentive to minimize respondent's treatment.

The Court of Appeals for the Seventh Circuit reversed the trial court's dismissal of respondent's amended Count III. 154 F.3d 362. Because respondent's allegations of medical malpractice (dealing with the quality of care respondent received) were resolved through trial, neither Dr. Pegram, nor any other individual physician, is a party to this appeal. Amended count III contains no allegations of medical malpractice, nor does it contain any allegation of negligent selection or supervision of physicians. There are no allegations

in amended count III implicating any individual clinical decisions, nor are there any allegations in amended count III implicating the health care that respondent received. Amended count III does not allege that the providing of medical services is a fiduciary function.

State Farm is not a party-defendant in amended count III. State Farm did not design and administer the incentive scheme alleged. (Pet. app. 85a). Rather, respondent specifically alleged that Carle Clinic, through its wholly-owned subsidiaries, designed and administered the incentive scheme. *Id.* In his dissent to the denial of petitioners motion for rehearing *en banc*, Justice Easterbrook acknowledges that petitioners, not State Farm, designed and administered this incentive scheme, referring to it as "Carle's setup." (Pet. app. 57a).

The only cost containment mechanism at issue in respondent's amended count III is the physician incentive to withhold treatment. Pre-paid health plans, especially HMOs, contain various cost-control mechanisms. *See* "Defining Full and Fair Disclosure in Managed Care Contracts," 60 The Citation, no. 6 (AMA, 1990). Respondent's amended count III does not attack capitation arrangements, nor discounted fee arrangements. It does not attack features that limit members to HMO physicians or to HMO facilities. Amended count III does not attack pre-certification, nor utilization review. Neither does it attack the primary care physician's role as "gatekeeper" of HMO services. The sole focus of attention of amended count III is the design and administration of an undisclosed physician incentive to withhold treatment.

In his dissent, Justice Flaum characterized the majority opinion as concluding that "the mere existence of this asserted conflict without more, gives rise to a cause of action for breach of fiduciary duty under ERISA." 154 F.3d at 381. But the majority stated:

That is not the conclusion we reach. Our decision does not stand for the proposition that the existence of incentives automatically gives rise to a breach of fiduciary duty. Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (i.e, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses).

The dissent admittedly does "not rule out the possibility that the imposition of incentives to limit care could support a claim of breach of fiduciary duty." In its view, such a claim might very well be viable when "there is a serious flaw in the manner in which the incentive arrangement is established . . ."

Having said this, we fail to see how it can conclude that Herdrich did not plead such a flaw in the structure of the incentive program at issue.

* * *

Thus, Herdrich alleges a "serious flaw" that springs from the authority of physician/owners of Carle to simultaneously control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals. Under the terms of ERISA, Herdrich most certainly has raised the specter that the self-dealing physician/owners in this appeal were not acting "solely in the interest of the participants" of the Plan. 154 F.3d 362, 373.

The court of appeals concluded:

> In summary, we hold that the language of the plaintiff's complaint is sufficient in alleging that the defendants' incentive system depleted plan resources so as to benefit physicians who, coincidentally, administered the Plan, possibly to the detriment of their patients. The ultimate determination of whether the defendants violated their fiduciary obligations to act solely in the interest of the Plan participants and beneficiaries, see U.S.C. § 1104(a)(1), must be left to the trial court. 154 F.3d 362, 380

SUMMARY OF ARGUMENT

1. Neither Dr. Pegram, nor any other individual physician, is a defendant in respondent's amended count III. Amended count III makes no allegation of medical malpractice — quality of care is therefore not at issue. Amended count III does not address cost containment mechanisms generally — it focuses solely on physician incentive schemes.

2. As non-sponsors, petitioners function as ERISA fiduciaries by:

   a) designing or "contracting" a physician incentive scheme whereby welfare benefit premiums are placed in a risk pool to fund health benefits, but physicians receive bonuses or "supplemental" income[2] from that same risk pool to the extent they withhold treatment; and

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2. payments over and above their salaries

b) administering disputed and non-routine health claims.

3. A non-sponsor fiduciary cannot serve in dual capacities, and the doctrine of judicial estoppel precludes petitioners from arguing that they are not fiduciaries in the first instance.

4. A subscription or membership certificate is not a welfare plan benefit. Rather, medical care is the benefit conferred and plan participants suffer directly when medical care is withheld.

5. Congress enacted a broadly-worded and functional definition of an ERISA fiduciary. Rather than exempting large categories of plan administrators (i.e., HMOs or other managed care organizations) from ERISA, courts should maintain oversight of benefit plans, and, drawing upon the common law of trusts, decide these issues in a conservative, case by case approach.

ARGUMENT

In 1973 Congress passed enabling legislation allowing the formation of "health maintenance organizations." 42 U.S.C. § 300e. This legislation allows HMOs to "make arrangements with physicians or other health professionals, healthcare institutions or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions." *Id.* This statute does not prescribe the mechanisms whereby the risk of health care is shifted. Nor does this enabling legislation recommend any type of risk shifting or cost containment mechanism. There is nothing in this statute that

can be construed as Congressional sanctioning of undisclosed physician incentives.

In 1985 and 1986, federal officials became aware of physician incentives in managed care.[3] In July of 1986, the U.S. General Accounting Office reported that some hospital physician incentive plans could lead to inappropriate reductions in service.[4] Certain commentators noted that the striking fact about incentive schemes is that they are generally not disclosed in subscription agreements or plan documents. *See* Havighurst, *Health Care Choices: Private Contracts as Instruments of Health Reform*, 122 (1995).

Congress recognized the need to address these incentive schemes: HMOs participating in the Medicare program are prohibited from issuing incentive payments to individual physicians as an inducement to reduce medical care. Section 4204(a)(1) of the Omnibus Budget Reconciliation Act of 1990 added paragraph (8) to § 1876(i) of the Social Security Act to specify that each medicare contract with an HMO must stipulate that the organization must meet the following requirements if it operates a physician incentive plan: (a) that it not operate a physician incentive plan that directly or indirectly makes specific payments to a physician or physician group as an inducement to limit or reduce medically necessary services to a specific individual enrolled with the organization; and (b) that it disclose its physician incentive plan arrangements in detail that is sufficient to allow the Department of Health and Human Services Health Care Financing Administration (HCFA) to

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3. GAO/HRD-89-29, "Medicare: HMO Physician Incentive Plans."

4. GAO/HRD-86-103, "Medicare: Physician Incentive Payments by Hospitals Could Lead to Abuse."

determine whether the arrangements comply with departmental regulations. *See* 42 CFR § 417.479.

At approximately the same time, the American Medical Association was attempting to assess the impact of physician incentives.[5] In 1990, the AMA published its report, "Financial Incentives to Limit Care: Financial Implications for HMOs and IPAs" and in June of 1994, the AMA's House of Delegates adopted the AMA's Council on Ethical and Judicial Affairs report, "Ethical Issues and Managed Care"[6], stating that, while efforts to contain costs are critical, managed care can "reduce the quality of care received by patients. In particular, by creating conflicting loyalties for the physician, some of the techniques of managed care can undermine the physician's fundamental obligation to serve as patient advocate. Moreover, in their zeal to control utilization, managed care plans may withhold appropriate diagnostic procedures or treatment modalities for patients," and finding:

> When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care should not place patient welfare at risk.

5. Some physicians argue that, while the new HCFA rules represent a sensible step, they are too limited in several senses: they apply only to managed care plans that contract with Medicare or Medicaid, and they require disclosure only if incentives exceed the 25% threshold, and only if enrollees explicitly request this information. *See* Mechanic & Schlesinger, "Impact of Managed Care on Patients' Trust", 275 JAMA no. 21 (June, 1996).

6. AMA Council on Ethical and Judicial Affairs, "Ethics and Managed Care," 273 JAMA no. 4 (Jan., 1995).

> Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.

Seeking to insulate its members from the obvious implications of hidden physician incentives, and based upon its 1990 report, in June of 1994 the AMA updated its Ethical Opinion 8.132 (Referral of Patients: Disclosure of Limitations) to read as follows:

> Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties. Because patients must have the necessary information to make informed decisions about their care, physicians have an obligation to assure the disclosure of medically appropriate treatment alternatives, regardless of cost.
>
> Physicians must assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients' overall access to care. Physicians may satisfy this obligation by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan. Physicians should also promote an effective program of peer review to monitor and evaluate the quality of the patient care services within their practice setting.[7]

Recognizing the egregious nature of the conflict of interest created by physician incentive schemes, the AMA sought to

7. *Id.*

lessen the impact of the conflict by mandating disclosure of the incentive schemes. The AMA seeks to place the burden of disclosure on plan administrators — a burden that was not met by petitioners here.

In 1998, the New England Journal of Medicine published a survey of 766 California managed care physicians.[8] Nearly 40% of those doctors reported that their HMO contracts included some form of bonus or other financial incentive designed to control costs. The median amount of the incentive actually received was $10,500, but 13% reported more than $40,000 "at risk." More than half of all physicians reporting incentives said they felt pressure from the plans to limit referrals and 17% believed the pressure was "sufficiently severe to compromise the quality of care." In an editorial accompanying that study, then-editor, Jerome P. Kassirer, suggested that HMO incentives to limit care represent an "intolerable threat to physicians' integrity."

Those same concerns are reflected in the findings of Concurrent Resolution 293 now before the U.S. House Subcommittee on Health & The Environment:

> Whereas payment arrangements in which health plans or individual health care providers reap a financial benefit from providing less care threaten to compromise the quality of care;
>
> * * *
>
> Whereas managed care's promise to slow health care inflation is questionable at best;

8. Grumbach, "Primary Care Physicians' Experience of Financial Incentives in Managed Care Systems." 339 N.E. J. Med. 1516 (1998).

* * *

> Whereas while the States have done an excellent job regulating health plans within their jurisdiction, over 120,000,000 Americans are enrolled in ERISA plans that are beyond the reach of State regulation;

No one can seriously contend that physician incentives benefit plan members. No one can seriously contend that physicians incentives don't create egregious conflicts of interest. The only question is whether ERISA can be used to address that conflict. For the reasons stated herein, respondent respectfully suggests the answer is yes.

I. A NON-SPONSOR FIDUCIARY MAY NOT DESIGN AND ADMINISTER AN ERISA BENEFIT PLAN SO AS TO INCREASE ITS PROFIT TO THE DETRIMENT OF PLAN PARTICIPANTS.

A. Petitioners Function as ERISA Fiduciaries When Designing and Administering a Welfare Benefit Plan

As stated by the Chairman of the House Committee on Education and Labor, 120 Cong. Rec. 3977, 3983 (Februrary 25, 1974) reprinted, 2 Legislative History of the Employee Retirement Income Security Act of 1974 at 3293:

> The Committee has adopted the view that the definition of fiduciary is of necessity broad . . . A fiduciary need not be a person with direct access to the assets of the Plan . . . Conduct alone may in an appropriate circumstance impose fiduciary obligations. It is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary . . .

In *Mertens v. Hewitt Associates*, 508 U.S. 248, 262 (1993), this court stated: "ERISA . . . defines "fiduciary" not in terms of formal trusteeship, but in functional terms of control and authority over the Plan. . . thus ***expanding*** the universe of persons subject to fiduciary duties." (emphasis added) ERISA's comprehensive regulation of employee welfare plans extends to those that provide "medical, surgical, or hospital care or benefits" for plan participants and their beneficiaries. 29 U.S.C. § 1002(1); *N.Y. Conference of Blue Cross v. Traveler's Ins.*, 514 U.S. 645, 649 (1995). ERISA does not go about protecting plan participants and their beneficiaries by requiring employees to provide any given set of minimum benefits, but instead ***controls the administration*** of benefit plans, *see* 29 U.S.C. § 1001(b), as by imposing reporting and disclosure mandates, §§ 101-111, 29 U.S.C. §§ 1021-1031, participation and vesting requirements, §§ 201-211, 29 U.S.C. §§ 1051-1061, funding standards, §§ 301-308, 29 U.S.C. §§ 1081-1086, and fiduciary responsibilities for plan administrators, §§ 401-414, 29 U.S.C. §§ 1101-1114. It envisions administrative oversight, imposes criminal sanctions, and establishes a comprehensive civil enforcement scheme. *Id.* (emphasis added). To "administer" a Plan is to "manage or supervise the execution . . . or conduct of" the Plan. Webster's *Ninth New Collegiate Dictionary* 57 (1991). *Dissent, Varity Corp. v. Howe*, 516 U.S. 489, 529, 530 (1996).

In its SPD, State Farm defers the administration of HMO benefits to the individual HMOs stating, "any and all benefit determinations will be made by each individual HMO according to its operating procedures." (Jt. app. 101, 102). In Section 8.3 of their Subscription Certificate, petitioners give themselves the discretion to determine what is and what is not medically necessary, excluding "services or supplies with are not, in the judgment of CarleCare Physicians, Medically Necessary for the medical treatment or for the maintenance of improvement

of the health of the Members." (Pet. app. 118a). In her complaint, respondent alleged that petitioners breached their ERISA fiduciary duties by funding their incentive scheme through two mechanisms: (1) designing the incentive scheme through its contracts, and then (2) administering the plan by determining what was or was not medically necessary. Paragraph 12(b) of the amended count III alleges:

> b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:
>
> i. by ***contracting***[9] with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:
>
> (1) minimize the use of diagnostic tests;
>
> (2) minimize the use of facilities not owned by CARLE; and
>
> (3) minimize the use of emergency and non-emergency consultation

9. Respondent does not allege, as contended by the Secretary, that petitioners seek to fund their incentive scheme by ***providing*** medical services. Rather, respondent alleges that petitioners seek to fund their incentive, in part, by ***contracting*** — that is to say, by negotiating, drafting and executing contracts — to employ undisclosed physician incentives.

and/or referrals to non-contracted physicians.

ii. ***by administering disputed and non-routine health insurance claims*** [10]and determining:

(1) which claims are covered under the Plan and to what extent;

(2) what the applicable standard of care is;

(3) whether a course of treatment is experimental;

(4) whether a course of treatment is reasonable and customary; and

(5) whether a medical condition is an emergency (Pet. app. 86a) (emphasis added)

The exercise of discretion in processing claims is the epitome of a fiduciary function.[11] *See* Cantor, "Fiduciary

10. Respondent made no allegations concerning ministerial duties attendant upon Plan administration. Rather, respondent addressed her allegations to discretionary duties — the administering of disputed and non-routine claims.

11. *Florence Nightingale Nursing Serv. v. Blue Cross/Blue Shield of Ala.*, 41 F.3d 1476 (11th Cir., 1995) ("Blue Cross was and is the claims administrator for the Plan and, in that capacity, had the fiduciary responsibility for receiving, processing, and paying claims"); *Pacificare v. Martin*, 34 F.3d 834, 837 (9th Cir., 1994) ("[i]nsurers can be ERISA (Cont'd)

Liability in Emerging Health Care," DePaul Bus. L.J., 189, 190 (1997). A decision that a particular benefit is not covered by the plan involves plan administration, even though there is a medical component to the decision. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992).

On pages 20 through 24 of her brief, the Secretary argues that the administration of a health benefit plan is a fiduciary function. Respondent concurs. The Secretary also argues that petitioners have acknowledged their fiduciary status and duty of loyalty by arguing on page 28 of their brief that an HMO, "must make coverage and eligibility decisions under the plan with an 'eye single' to the interest of the patient/beneficiaries." (Sec. Br. 26)[12] Again, respondent concurs. Furthermore, the Secretary has propounded regulations addressing claims

(Cont'd)
fiduciaries if, 'they are given the discretion to manage plan assets or to determine claims made against the Plan [; a]n insurer will be found to be an ERISA fiduciary if it has the authority to grant, deny or review denied claims'"); *Doe v. Group Hosp. & Med. Servs.*, 3 F.3d 80, 85 (4th Cir., 1993) ("Blue Cross both insures and administers the payment of health care benefits . . . [; i]n its role as plan administrator, Blue Cross clearly exercises discretionary authority or discretionary control with respect to the management of the Plan and therefore qualifies as a fiduciary under ERISA"); *Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416, 419 (7th Cir., 1988) ("[a]s the administrator of the employee benefit plan, Blue Cross is a fiduciary for ERISA purposes.")

12. The Secretary is also correct to point out that, on page 7 of their reply brief at the writ stage, petitioners "freely acknowledge that they are plan fiduciaries when they engage in activities denominated as fiduciary by ERISA, e.g., when they provide information to participants as required under ERISA ***and when they make decisions about who is eligible for plan benefits***." (emphasis added).

administration.[13] 29 CFR 2509.75-8 states that the determining of benefit eligibility is a fiduciary function if discretion is exercised, i.e., if it involves more than ministerial functions. 29 CFR 2560.503-1 imposes ERISA fiduciary duties on those who implement the plan's claims procedure. Petitioners' argument that they were not acting as ERISA fiduciaries when designing and administering this Plan begs the question: When non-sponsors design, implement and administer an ERISA health plan, in what capacity are they serving? [14]

When an HMO contracts with an employer to provide medical benefits to its employees, the HMO does not set a premium that is calculated at merely a "break even" level. Rather, the premium charged to the employer by the HMO already has an "underwriting profit" or "after-tax return" built into it. Accident and health insurance is a property and casualty line of insurance, as opposed to being governed by the principles of life insurance ratemaking. The 1988 "Statement of Principles Regarding Property and Casualty Insurance Ratemaking" of the Casualty Actuarial Society states:

> The purpose of this Statement is to identify and describe principles applicable to the determination

13. Department of Labor Regulations have been given substantial weight by courts interpreting the provisions of ERISA. *See Lowen v. Tower Asset Management, Inc.*, 653 F. Supp. 1542, 1555 n.10 (S.D.N.Y.), *aff'd*, 829 F.2d 1209 (2nd Cir., 1987).

14. Petitioners do not really attempt to answer this question. Instead, they seek to argue that State Farm designed and implemented the incentive plan. This argument assumes facts that directly contradict the Plan documents and the allegations of the complaint, which clearly state that petitioners designed, implemented and administered the incentive scheme.

> and review of property and casualty insurance rates. The principles in this Statement are limited to that portion of the rate making process involving the estimation of costs associated with the transfer of risk.

In its section on definitions, the Statement indicates that "ratemaking is the process of establishing rates used in insurance and other risk transfer mechanisms," and that the Statement "is limited to principles applicable to the estimation of these costs," which "costs" include profit: "The underwriting profit and contingency provisions are the amount that, when considered with the net investment and other income, provide an appropriate total after-tax return." In his *Essentials of Managed Health Care*, 2nd ed., (ch. 23, Rating & Underwriting) (Aspen, 1997), author Kongstvedt describes how HMOs are obligated to use "community-based rating" and how the medical care of a member is expressed in terms of "per member — per month." Kongstvedt advocates the use of a "premium loading factor." After demonstrating how the cost of providing medical services, "per member — per month," might result in a figure of $120, the author then uses a premium loading factor of 1.19 which means that, although the actuarial projection of medical costs "per member — per month" is only $120, the monthly premium charged to the employer is $142.80.

Moreover, the monthly premium charged to the employer is not the capitation payment forwarded to doctor actually providing the healthcare. From the capitation payments, HMOs make allocations to various funds, or risk pools, to pay for (1) primary care services, (2) specialty physician or referral services, and (3) institutional services, such as in-patient hospital and

skilled nursing facility services.[15] Physician incentive payments generally come from these risk pools. *Id.* The Secretary's argument in note 4 on page 11 of her brief that petitioners had control over no assets because there was "apparently no underlying trust" is incorrect. Petitioners had complete control of the risk pools. The risk pools are assets of the Plan. Petitioners' management of those risk pools is a fiduciary function under ERISA.

It is important to note that neither Dr. Pegram, nor any other individual physician, is a party-defendant in amended count III. None of the facts set forth in amended count III alleged deviation from the required standard of medical care, or even negligent selection of physicians. In fact, there are no negligence allegations contained in amended count III. Moreover, the allegations of amended Count III do not address the quality of the healthcare that respondent received. The Secretary misreads respondent's complaint when arguing that petitioners were not acting as fiduciaries under the "treatment allegations." (Secretary's brief at 16) There are no "treatment allegations." The Secretary fails to give effect to the first clause in respondent's paragraph 12(b)(i) of the complaint which alleges, "***by contracting*** with CARLE owner/physicians" (Pet. app. 86a) (emphasis added) petitioners created and managed risk pools from which they paid themselves bonuses funded by the withholding of medical treatment.[16]

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15. GAO\HDR-89-29 "Medicare: HMO Physician Incentive Plans" p. 14

16. The allegations of respondent's amended count III do not seek to raise mere allegations of medical malpractice to the level of breach of ERISA fiduciary duties. Respondent concurs with the Secretary, and the *amicus* brief of the American Medical Association, that the providing of medical services by an HMO physician is not a fiduciary (Cont'd)

B. Non-Sponsor Fiduciaries Cannot Operate in Dual Capacity

From the Plan documents and respondent's allegations, it is clear that petitioners, and not State Farm, designed and administered the plan benefits at issue here. Petitioners attempt to avoid liability by arguing that they serve in a "dual capacity" and that ***to the extent*** that they are only making entrepreneurial decisions, they are not serving in a fiduciary capacity. This argument does not withstand scrutiny. Firstly, although ERISA does contemplate dual capacities (29 U.S.C. § 1108(c)(3)), respondent is unaware of any cases in which dual capacity has been conferred upon any party other than a plan sponsor (i.e., employer, union representative, etc.)[17] In *Varity,* the dissent explained the basis of the "to the extent" clause when it stated:

> This "artificial definition of fiduciary," *Mertens, supra* at 255, n.5, is designed, in part, so that an employer that administers its own plan is not a

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(Cont'd)
function and that traditional medical malpractice actions should be left to state regulation.

It is also important to note that petitioners' decision to force respondent to wait an additional eight days for a sonogram after discovering respondent's abdominal mass is an administrative, not a medical decision. That is to say, there was no medical necessity that respondent wait eight days or that respondent use petitioners' sonography equipment.

17. *See* Annot., "Dual Loyalty Considerations in Determining Propriety Under Employee Retirement Income Security Act (29 U.S.C. §§ 1001 *et. seq.*), of Actions of Officers of Sponsor Corporations Serving as Trustees of Employment Pension Plans," 64 ALR Fed. 602 (Lawyer's Co-op., 1983).

> fiduciary to the plan for all purposes and at all times, but only to the extent that it has discretionary authority to administer the plan. When the employer is not acting as plan administrator, it is not a fiduciary under the Act, and the fiduciary duty of care codified in Section(s) 404 is not activated. *Varity* at 528.

Courts and commentators have long recognized that, because ERISA does not mandate that plans be established and that certain benefits be offered,[18] plan sponsors occupy a distinctive role.[19] Protection afforded by the "to the extent" clause or by "dual capacity" status, inures to the benefit of a plan sponsor — but only to a plan sponsor.[20] Moreover, petitioners are precluded from arguing that they are not fiduciaries. The petitioners' briefs before this Court contradict the representations they made in order to have the case removed and preempted. Now, petitioners argue that if the Court finds they are fiduciaries, it would unduly broaden preemption under ERISA! (Pet. Br. p. 37) Judicial estoppel and equitable estoppel prevent parties from manipulating the courts in this manner.

The doctrines of judicial and equitable estoppel, although clearly recognized by this Court,[21] have largely been developed

18. *N.Y. Conference of Blue Cross & Blue Shield Plans v. Travelers, Ins.*, 514 U.S. 645 (1995).

19. Fischel and Langbein, "ERISA's Fundamental Contradiction: The Exclusive Benefit Rule," 55 Univ. Chi. L. Rev. 1105 (1988).

20. As they did in their petition for writ of certiorari, petitioners again cite *Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755 (1999) and *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996). But those cases are inapposite as, unlike the case at bar, each dealt solely with the actions of a plan sponsor.

21. *See Cleveland v. Policy Management Systems Corporation, et al.*, 526 U.S. 795 (1999) (holding that plaintiff's ADA claims will (Cont'd)

by the courts of appeal. Although the courts of appeal have adopted slight variations in their interpretations of judicial estoppel, it is clearly intended to prevent parties from manipulating the courts by "gain[ing] an advantage by taking one position, and then seeking a second advantage by taking an incompatible position." *Cigna Property and Casualty Ins., Co. v. Polaroid Pictures Ass'n.*, 159 F.3d 412, 419 (9th Cir., 1998). The Seventh Circuit noted that judicial estoppel is "to protect the courts from being manipulated by chameleonic litigants who seek to prevail, twice, on opposite theories." *Levinson v. United States*, 969 F.2d 260, 264 (7th Cir., 1992).

> A party can argue inconsistent positions in the alternative, but once it has sold one to the court it cannot turn around and repudiate it in order to have a second victory, which is what the IRS is seeking here. Having persuaded us to reject Continental's efforts to show that the taxes were paid, the IRS may not argue against a restatement of income on the ground that they were really paid. Either they were or they weren't.

Continental Illinois Corp. v. C.I.R., 998 F.2d 513, 519 (7th Cir., 1993). "Equitable estoppel serves to protect ***litigants*** from unscrupulous opponents who induce a litigant's reliance on a position, then reverse themselves to argue that they win under an opposite scenario." *Teledyne Industries, Inc. v. N.L.R.B.*, 911

(Cont'd)
not be automatically estopped because of a prior filing from SSDI benefits); *Huffman, et al. v. Pursue, Ltd.*, 420 U.S. 592 (1975) (merely noting that the court does not intend for its opinion to affect the overall rules of judicial estoppel in footnote 18); *Buck v. Quykendall*, 267 U.S. 307 (1925) ("a person who has invoked the benefit of an unconstitutional law cannot in a subsequent litigation aver its unconstitutionality as a defense.") (citations omitted).

F.2d 1214, 1220 (6th Cir., 1990), citing to *Moser v. United States*, 341 U.S. 41 (1951). (Emphasis added).

Equitable estoppel should apply here but, in the alternative, should this Court find that equitable estoppel does not apply, judicial estoppel should apply. Judicial estoppel examines the connection between the litigant and the judicial system, while equitable estoppel focuses on the relationship of the parties to the prior litigation. *Oneida Motor Freight, Inc. v. New Jersey Bank*, 848 F.2d 414, 419 (3rd Cir., 1988); *c.f. Lydon v. Boston Sand & Gravel*, 175 F.3d 6 (1st Cir., 1999) (judicial estoppel's dual goals are "to maintain the integrity of the judicial system ***and*** to protect parties from opponent's unfair strategies.")

Even ignoring the fact that, as non-sponsor fiduciaries, petitioners cannot claim they were acting in a "dual capacity," and even ignoring the fact that petitioners should be judicially estopped from now claiming they were not fiduciaries, petitioners' assertion that they were merely making a "business" or "entrepreneurial" decision fails. Respondent acknowledges that, as the plan sponsor, State Farm's business or entrepreneurial decision to offer group medical and an HMO is a decision beyond the purview of ERISA. But the implementation of this particular HMO is a different matter. Petitioners, not State Farm, implemented the particulars of this HMO. Courts have routinely held that implementation decisions are fiduciary decisions. *See Waller v. Blue Cross of California*, 32 F.3d 1339 (9th Cir., 1994); *District 65, United Auto Workers v. Harper & Row Publishers, Inc.*, 670 F. Supp. 550 (S.D.N.Y., 1987); *Cooke v. Lynn Sand & Stone Co.*, 673 F. Supp. 14 (D. Mass., 1986).

In other cases, the Secretary has argued that, if implementing an incentive scheme was considered to be an act

of plan administration, it would lead to an absurd result. *See* Secretary's *amicus* brief in *Lancaster v. Kaiser Foundation Health Plan of the Mid-Atlantic States*, 958 F. Supp. 1137 (E.D. Va., 1997). The Secretary explained that an HMO (Kaiser) has a financial incentive to arrange for medical care at the least expense to itself and that its decisions are business decisions because Kaiser could not effectively conduct itself as a business due to an inherent conflict of interest — its interest in keeping financially sound would conflict with its duty as a fiduciary to act solely in the interest of the participants. This raises an absolutely critical point in this case. Here HAMP, the entity hiring the doctors, is, in fact, the doctors. One is the alter ego of the other. Here there is no "absurd result" and there is no inherent conflict.

In their implementation of State Farm's decision to offer an HMO, petitioners created and administered a risk pool for health benefits from which petitioners paid themselves bonuses to the extent they withheld treatment.

II. STRUCTURAL CONFLICTS ARE ACTIONABLE UNDER SECTION 406 "PER SE" PROHIBITIONS, WHETHER DIRECT OR INDIRECT.

The Secretary acknowledges that an incentive scheme constituting a breach of fiduciary duty would be established

> if the scheme provided incentives of such a nature that the individual deciding claims for benefits would be unable to set aside personal interests and make the benefits determination based on the terms of the Plan . . . For example, a compensation scheme that provided direct financial incentives to plan fiduciaries for making adverse rulings on benefits claims . . .

(Sec. Br. 28, 29) But the Secretary concludes that nothing in respondent's amended count III "suggests that respondent was intending to plead that petitioners employed the kind of unusual incentive scheme described above, in which those who decided disputed claims would be paid on the basis of how many claims they deny or would otherwise be paid in a way that violates ERISA's fiduciary duty." (Sec. Br. 29). The Secretary's analysis places far too great a pleading burden on respondent, and also fails to acknowledge that the "per se" prohibitions of § 406 prohibit any self-dealing, whether it is achieved directly or indirectly.

Respondent's amended count III was dismissed pursuant to Fed. R. Civ. P. Rule 12(b)(6). (Pet. Br. 10). To withstand a Rule 12(b) motion, respondent's allegations need only state a possible claim, not a winning claim. *See Conley v. Gibson*, 355 U.S. 41, 45-46 (1957). A complaint may be dismissed for failure to state a claim only if it is clear that no relief could be granted under any set of facts that could be proved consistent with the allegations. *Hishon v. King & Spaulding*, 467 U.S. 69 (1984). A complaint should not be dismissed unless it appears beyond doubt that that plaintiff can prove no set of facts in support of her claim which would entitle her to relief. *McLain v. Real Estate Bd. of New Orleans, Inc.*, 44 U.S. 232 (1980). For purposes of withstanding a Rule 12(b) motion to dismiss, "notice pleading" is sufficient. *Sinclair v. Kleindienst*, 711 F.2d 291 (D.C. Cir., 1983). The federal rules do not require a plaintiff to allege sufficient facts to establish her right to judgment. All that is required is a "short and plain" statement of what her claim is. Fed. R. Civ. P. 8(a)(2).

In paragraph 11 of her complaint, respondent quoted the "duty of loyalty" language of ERISA § 404(a) (29 U.S.C. § 1104(a)). A fiduciary's "duty of loyalty" under ERISA cannot

be understood without comparing the prohibited transaction scheme of ERISA with the duty of loyalty under the common law of trusts. Based on such a comparison, a compelling argument can be made that the drafters of ERISA consciously intended §406 to prohibit "structural conflicts" that were not always addressed by the common law. Klevan, "The Fiduciary's Duty of Loyalty Under ERISA Section 406(b)(1)," 23 Real Property, Probate and Trust Journal, 561 (1988)[22] The heart of a fiduciary's duty of loyalty is contained in ERISA § 404(a)(1) and is repeated and reinforced in the prohibited transactions provisions of § 406 which provides:

> **(a) Transactions between plan and party in interest.** Except as provided in section 408 [29 U.S.C. § 1108]:
>
> (1) A fiduciary with respect to a plan shall not cause the plan to engage in a transaction, if he knows or should know that such transaction constitutes a direct or indirect —
>
> (A) sale or exchange, or leasing, of any property between the plan and a party in interest;
>
> (B) lending of money or other extension of credit between the plan and a party in interest;
>
> (C) furnishing of goods, services, or facilities between the plan and a party in interest;

22. Mr. Klevan authored this article at the time that he was senior director of Policy and Legislative Analysis, Pension and Welfare Benefits Administration, U.S. Department of Labor.

(D) transfer to, or use by or for the benefit of, a party in interest, of any assets of the plan; or

(E) acquisition, on behalf of the plan, of any employer security or employer real property in violation of section 407(a) [29U.S.C. §1107(a)]

(b) Transactions between plan and fiduciary. A fiduciary with respect to a plan shall not —

(1) deal with the assets of the plan in his own interest or for his own account,

(2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or

(3) receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.

The prohibitions contained in § 406(a) are against "direct or indirect" transactions and are not simply the embodiment of the common law prohibition against the trustee engaging in self-dealing. They are also the extension, in absolute form, of the common law rule that transactions between a trust and a

third party may be set aside if it can be shown that the trustee was improperly influenced by its relationship to the third party, or even its friendship with the third party, so that the trustee engaged in a transaction that was less advantageous to the trust than if the trustee were dealing at arm's length. Klevan at 563. Section 406 provides a per se prohibition of these transactions with a category of persons known as ERISA § 3(14) "Parties in Interest," which includes both fiduciaries and service providers to the Plan.[23] Instead of requiring proof that a fiduciary's relationship with a third party might influence the best judgment of the fiduciary, it substituted an absolute rule that defines by statute those persons who are deemed to have such an influence. Thus, Congress dispensed with the need to show that the fiduciary was actually influenced to the detriment of the Plan. Klevan at 564.

Klevan also states that the Department of Labor's position is that a § 406(b)(1) prohibition (barring self-dealing with plan assets) is a per se prohibition requiring a plan fiduciary who has a conflict of interest to step aside. Courts have had little difficulty in finding § 406(b)(1) violations in transactions between a plan and a fiduciary, given a direct conflict of interest in which the fiduciary's gain is the plan's loss. Klevan at 570.

Additionally, respondent takes issue with the Secretary's characterization of the conflict created by petitioner's incentive scheme as being "indirect." Respondent alleged that HAMP created a structural conflict of interest by "contracting" to withhold treatment so that the savings realized can, in turn, be paid to HAMP's owners — those same Carle physicians. This is hardly an "indirect" conflict of interest. In fact, it is difficult

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23. 29 U.S.C. § 1002(14) states: [t]he term "party in interest" means, as to any employee benefit plan — (A) any fiduciary . . . (B) a person providing services to such plan.

to envision a more direct conflict. Every dollar saved by not ordering sonograms, by not referring patients to surgeons, or by refusing to send patients to the emergency room, goes directly into the pockets of petitioners. Respondent's allegations clearly make a claim for a direct conflict of interest.

Like Justice Easterbrook in his dissent to the denial of petitioner's motion for rehearing (Pet. app. 48a), petitioners argue that the plan participants here suffered no loss. Petitioners and Justice Easterbrook argue that the benefit conferred is mere membership in the Plan, not the benefits to be provided thereunder. Of course, employing this analysis, the employees of Massey Combines[24] would have had no cause of action because they still had membership in the Massey Combines nonpension benefits plan, it being irrelevant that the sponsor of that plan was bankrupt. But this court has rightly decided that the specific benefits conferred, not the naked subscription certificate, is the benefit offered (or, in this case, the benefit lost). *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *UNUM Life Ins. Co. v. Ward*, 119 S. Ct. 1380 (1999). The Secretary is correct to disagree with the analysis of Justice Easterbrook. Here the very money that should have paid for respondent's emergency room visit, that should have paid for respondent's timely sonogram in her hometown, and that should have paid for respondent's surgery at the nearest hospital, instead went into petitioners' pockets. Respondent suffered a direct loss of benefits, as has each and every member of CarleCare HMO.

In her approach, the Secretary acknowledges that petitioners are fiduciaries, but argues that, as a matter of law, respondent has failed to allege any violation under ERISA because ERISA contemplates dual loyalties (Sec. Br. 28) and because the incentive scheme here is nothing more than a mechanism to

24. *See Varity v. Howe*, 516 U.S. 489 (1996).

compensate the petitioners who, as fiduciaries, are entitled, pursuant to 29 U.S.C. § 1108(c), to compensation for performance of their duties. (Sec. Br. 9).

But the Secretary's analysis is incomplete. Section 1108(c) has three subsections:

> **(c) Fiduciary benefits and compensation not prohibited by 29 U.S.C. § 1106.** Nothing in section 406 [29 U.S.C. § 1106] shall be construed to prohibit any fiduciary from —
>
> (1) receiving any benefit to which he may be entitled as a participant or beneficiary in the plan, so long as the benefit is computed and paid on a basis which is consistent with the terms of the plan as applied to all other participants and beneficiaries;
>
> (2) receiving any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually incurred, in the performance of his duties with the plan; except that no person so serving who already receives full-time pay from an employer or an association of employers, whose employees are participants in the plan, or from an employee organization whose members are participants in such plan shall receive compensation from such plan, except for reimbursement of expenses properly and actually incurred; or
>
> (3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

Subsections 1 and 3 are inapplicable on their face. The Secretary must be suggesting that nothing in §406 prohibits a fiduciary from receiving "reasonable compensation for services rendered" pursuant to § 1108(c)(2). The Department of Labor's regulation on this section (29 CFR § 2550.408(c)(2)) provides in pertinent part:

> (2) *Payments to certain fiduciaries*. Under sections 408(b)(2) and 408(c)(2) of the Act, the term "reasonable compensation" does not include any compensation to a fiduciary who is already receiving full-time pay from an employer or association of employers (any of whose employees are participants in the plan) or from an employee organization (any of whose members are participants in the plan), except for the reimbursement of direct expenses properly and actually incurred and not otherwise reimbursed. The restriction of this paragraph (b)(2) do not apply to a party in interest who is not a fiduciary.

Petitioners are excluded from protection under 408(c)(2) because they are already paid a salary as full-time employees of Carle Clinic and/or HAMP.[25] Even if those physicians were not salaried, but instead retained the "per member — per month" capitation payment, they would still be disqualified from protection under section 1108(c)(2). 29 CFR § 2550.408(c)(2) further states:

> (5) *Excessive compensation*. Under sections 408(b)(2) and 408(c)(2) of the Act, any compensation which would be considered excessive

25. In her complaint, respondent alleged that the incentive scheme payments were "supplemental." (Pet. app. 86a).

> under 26 CFR 1.162-7 (Income Tax Regulations relating to compensation for personal services which constitutes an ordinary and necessary trade or business expense) will not be "reasonable compensation." Depending upon the facts and circumstances of the particular situation, compensation which is not excessive under 26 CFR 1.162-7 may, nevertheless, not be "reasonable compensation" within the meaning of sections 408(b)(2) and 408(c)(2) of the Act.

While 26 CFR 1.162-7[26] addresses the deductibility of ordinary and necessary business expenses, it nonetheless establishes that the applicable test is whether compensation is "reasonable" and whether it is "in fact payments purely for services." The Department of Labor has adopted the framework that the Internal Revenue Service regulations employ to determine if there is an excessive payment in contravention of 29 U.S.C. § 1108.[27]

26. 26 CFR 1.162-7 states: "§ 1.162-7. **Compensation for personal services**

> (a) There may be included among the ordinary and necessary expenses paid or incurred in carrying on any trade or business a reasonable allowance for salaries or other compensation for personal services actually rendered. The test of deductibility in the case of compensation payments is whether they are reasonable and are in fact payments purely for services.

27. It is important to note that the Department of Labor clearly intended a *broader* definition of excessive compensation to be used in the ERISA context than the definition used in the Internal Revenue Service. Regulation 2550.408(c)-2 makes the violation of 26 CFR 1.162-7 sufficient but not necessary for a determination that compensation is not "reasonable."

I.R.S. regulations prohibit certain types of excessive compensation in order to protect the tax base. Specifically, the IRS is concerned with corporations attempting to avoid taxation by calling what is really a dividend a "salary" and thereby claiming a deduction. *Dexsil Corporation v. Commissioner of Internal Revenue*, 147 F.3d 96 (2nd Cir., 1998).

The purpose of preventing excessive compensation in an ERISA context is to protect Plan benefits. State Farm and the Plan participants paid premiums to HAMP. That money was held by HAMP in a risk pool to provide for the medical care of the participants. Payments received by petitioners from the risk pool are not "in fact payments purely for services." Indeed, they are payments for ***not*** providing services.

The Secretary's argument with respect to petitioners being entitled to "reasonable compensation" has not been accepted by the courts. In *Gilliam v. Edwards*, 492 F. Supp. 1255 (D.C.N.J.), a union business manager agreed to act as an administrator of the union pension fund pursuant to a contract whereby he would be paid for his services as administrator. But when challenged by union participants, the court held that the business manager was not exempt under § 408(c)(2) because his salary as business manager was substantial enough to qualify as full-time pay, and therefore any additional compensation he received as administrator was not "reasonable compensation." In *Marshall v. Snyder*, 1 EBC 1878 (E.D.N.Y., 1979), a salaried trustee was not allowed to receive a "severence benefit." In *Marshall v. Kelly*, 465 F. Supp. 341, (W.D.Ok., 1978), a trustee receiving full-time pay was not allowed to keep a $9,000 sales commission for selling property owned by the plan. In *Donovan v. Daugherty*, 550 F. Supp. 390 (S.D.Ala., 1982), trustees receiving full-time pay were not allowed to receive additional "monthly payment" benefits.

The Secretary argues that respondent has not stated a cause of action because, under "typical arrangements" for employee benefit plans, such as an insured health plan where the insurer has discretionary authority to decide claims, or a plan under which a company employee has such authority and the employer pays claims out of its own assets, there is some measure of divided loyalty on the part of the claims decisionmaker. (Secretary Br. 28) The analogy does not hold. A third-party administrator whose individual income does not depend on the denial of claims is hardly analogous to an administrator who is a party in interest and whose income is based, in large part, upon denials. In the majority opinion, Justice Coffey correctly observed that, "[t]olerance, in other words, has its limits." 154 F.3d at 373.

The Secretary also argues that, if an HMO's business decisions, such as how to compensate physicians for their treatment of patients, where subject to ERISA fiduciary provisions, it is difficult to understand how the HMO could function as a business entity. (Secretary Br. 18) The Secretary has answered her own question. An HMO can easily make business decisions as to how to compensate its physicians by simply insuring that claims decisions are made by independent third-party administrators. Using the Secretary's own "typical arrangements" analogy, simply remove the claims administration function from the hands of any physicians whose income depends upon claim denials. Indeed, the simple expediency of using an independent third-party administrator was the very course suggested in *Donovan v. Bierwirth*, 680 F.2d 263 (2nd Cir.), *cert. denied*, 459 U.S. 1069 (1982) where the court advised the fiduciaries to seek "someone above the battle." *Donovan* at 272-273. This case would not be before this Court if the petitioners' claims administration was performed by anyone other than the physicians whose income depended on claims denials.

III. ERISA'S FIDUCIARY DUTIES ARE BASED ON THE COMMON LAW DUTY OF LOYALTY.

ERISA's fiduciary duties draw much of their content from the common law of trusts, the law that governed most benefit plans before ERISA's enactment. *Varity* at 496; H.R. Rep. No. 93-533, pp. 3-5, 11-13 (1973), 2 Legislative History of the Employment Retirement Income Security Act of 1974 (Committee Print compiled for the Senate Subcommittee on Labor of the Committee on Labor and Public Welfare by the Library of Congress), Ser. No. 93-406, pp. 2350-2352, 2358-2360 (1976). Rather than specifically enumerating all the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility. *Central States, S.E.. & S.W. Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985). With respect to ERISA's fiduciary duties, courts are to apply common law trust standards "bearing in mind the special nature and purpose of employee benefit plans." H.R. Conf. Rep. No. 93-1280, p. 302, 3 Leg. Hist. 4569.

The bedrock concept that remains in all health plans governed by ERISA is that the Plan will have one or more fiduciaries who will manage the plan with loyalty and an "eye single" toward the interests of the plan participants. *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2nd Cir., 1982), *cert. denied* 459 U.S. 1069 (1982); Cantor, "Fiduciary Liability in Emerging Health Care," DePaul Bus. L.J., 189, 190 (1997). The "solely in the interest" standard is the most fundamental of ERISA's standards imposed by § 404(a)(1). Polk, *ERISA Practice & Litigation*, § 303(a) (West.1999 Supp.) Section 404(a)(1)(A) imposes a duty to act for the "exclusive purpose" of providing benefits and deferring reasonable administrative expenses, which is an extension of the common law duty of loyalty.

Central States at 570. To deter a trustee from all temptation and to prevent any possible injury to the beneficiary, the rule against a trustee dividing his loyalties must be enforced with "uncompromising rigidity." A fiduciary cannot contend that, although he had conflicting interests, he served his masters equally well or that his primary loyalty was not weakened by the pull of his secondary one. *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329 (1981).

Here the Court of Appeals correctly ruled that this duty of loyalty is directed particularly at schemes "tainted by a conflict of interest and thus highly susceptible to self-dealing." 154 F.3d at 371. The Court of Appeals specifically noted that, in the case at bar, members of the benefit plan's administrative review board "were the very owners of the plan, and plan beneficiaries were without a single representative on the board." 154 F.3d at 378. The court further noted that the Plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of the cost savings. 154 F.3d at 372.[28]

One of the overriding goals of ERISA is to prevent the misuse and mismanagement of plan assets by fiduciaries. *See Massachusetts Mutual Life Ins., Co. v. Russell*, 473 U.S. 134, 140 (1985). To achieve that goal, ERISA § 409(a), (29 U.S.C. § 1109(a)) requires a fiduciary to disgorge to an employee benefit plan, any profits made through improper use of plan assets. *Id.* Section 409(a) makes administrators liable

28. The court of appeals concluded that the self-dealing administrators here were no different than the broker who was guilty of "churning" the securities of a profit-sharing plan. *Dasler v. E.F. Hutton & Co., Inc.*, 694 F. Supp. 624 (D. Minn., 1988).

for breach of their fiduciary duties and specifies the remedies available against them, including restitution. ERISA § 404(a)(1) (29 U.S.C. § 1104(a)(1)) defines the duty of loyalty in terms similar to those in the Restatement (Second) of Trusts. Under the Restatement, when a trustee breaches his duty of loyalty, the beneficiary may bring suit to recover any profits made through the breach.

The foresight of Congress in drawing upon the common law of trusts not only allows courts to fashion equitable remedies to address the wrong at hand, it also allows the courts to engage in specific analysis on a case by case basis. Given the incredible number of managed care organization permutations (i.e., HMOs, PPOs, IPAs, etc.) and given the wide variety within even those sub-categories, it is unlikely that a black-letter rule of law could offer the necessary protection to plan participants. Neither is it advisable to legislate specific guidelines, as the rapid pace of evolution of healthcare organizations would greatly outpace such guidelines. The beauty of the common law is that, like biblical parables, the themes are both fluid and timeless. Respondent respectfully suggests that this Court decline petitioners' invitation to place certain entities beyond the reach of ERISA's common law tenets.

CONCLUSION

The decision of the Court of Appeals should be affirmed.

Respectfully submitted,

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